



LIHEAP Application

Low Income Home Energy Assistance Program

Si Ud. necesita este formulario en español, comuníquese con su trabajador(a)

THIS APPLICATION MAY ONLY BE USED FOR THE LIHEAP PROGRAM

Answer all the questions on the form. You must sign and date the last page of the Application in order for it to be valid. If you would like to receive another type of help that you do not already get, please contact your caseworker and ask for an ISD-100 or ISD-SP101 application form.

FOR OFFICE USE ONLY	Date Received	Worker Name	Disposition Date
----------------------------	----------------------	--------------------	-------------------------

▼ APPLICANT Section ▼

1. Address

Write in your current physical and mailing address

Home Address – Physical Address	City	State	Zip Code	Telephone Contact # ()
Mailing Address if Different from home address	City	State	Zip Code	

2. You and People Who Live with You

A. List names and information for yourself and all the people who live with you. You only have to give a Social Security Number and give citizen information for the persons who are applying for or receiving assistance.

Name (First and Last)	Social Security #	Sex M = Male F = Female	Date of Birth	Age	Race	Citizenship US = United States I = Immigrant	Disabled?
(You)							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

B. Do you get Food Stamps, Medicaid, or Cash Assistance like TANF, GA, or SSI? Yes No

C. If you are Native American, do you live on your Reservation? Yes No If Yes, which one? _____

3. Income

A. Checkmark all sources of income including benefits for all household members and attach proof of the income for the last 30 days.

- | | | | |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> Employment | <input type="checkbox"/> Cash Assistance | <input type="checkbox"/> Social Security | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Unemployment | <input type="checkbox"/> Dividends | <input type="checkbox"/> Veterans | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Military | <input type="checkbox"/> Tribal monies | <input type="checkbox"/> Other _____ |

B. List all the income information for each household member:

Person with Income	Income from?	\$ Amount Before Taxes	How Often? Weekly, Biweekly, Monthly, Semi Monthly
		\$	
		\$	
		\$	
		\$	

4. Home Heating, Cooling and Telephone

A. Which best describes your home costs?

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Public Housing – \$0 rent | <input type="checkbox"/> Public Housing – I pay rent | <input type="checkbox"/> Renting –Not Public Housing | <input type="checkbox"/> Home Owner |
| <input type="checkbox"/> Living with Others – \$0 rent | <input type="checkbox"/> Living with Others – I pay rent | <input type="checkbox"/> Other _____ | |

B. Please choose one heating or cooling energy bill that you want help with.

- Propane/Butane Natural Gas Wood
 Electric Coal Other _____

C. Is this energy bill included in your rent payment? Yes No

D. What is the name of the energy company, fuel provider or landlord that you pay? _____

E. If this energy bill is not in your name, what is the customer's name on the account? _____

F. What is the Account Number? _____

G. How much was your highest monthly bill in the last 12 months? \$ _____

Please provide a copy of your bill or receipts for fuel. If eligible, HSD will send your payment to your heating or cooling fuel provider unless they do not accept LIHEAP payments.

H. Please tell us about your telephone bill. If you are eligible for LIHEAP you may also be eligible for a telephone discount from one telephone company. Not all telephone companies offer this discount. HSD will notify the telephone companies that offer this discount.

I. Who do you pay (company name)? **J. Whose name is the bill in?** **K. What is the Account Number?**

5. Your Signature

You must sign this form to make this application valid. Your application will not be processed unless signed

- I have given HSD true, correct and complete information
- I understand that making false statements or hiding information could mean state and federal penalties and denial of assistance
- I will give proof of things I report to HSD. If I cannot get proof, I know that I can ask HSD to help me and I will let HSD contact other people, and companies to get proof
- I will let HSD give limited information to approved agencies which provide other energy/weatherization help for which I may be eligible
- I will let HSD give limited information to my heating, cooling, and telephone service providers in order to provide federal and state benefits
- I understand that if I receive benefits I am not eligible for, that I may have to pay HSD back for those benefits
- I know that HSD will check the information that I give. HSD may use computers to check the information on this form

I affirm under penalty of perjury that the statements made about persons in my home, income, and all other information I have given HSD are true and correct

▶ Sign Here X _____ Today's Date _____

You Can Register to Vote Here

If YOU are NOT registered to vote where you live now, Would you like to register to vote here today? (Please check one) **Yes** **No** **IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**


The NATIONAL VOTER REGISTRATION ACT provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

IMPORTANT: Applying to register or declining to register to vote WILL NOT AFFECT the amount of assistance that you will be provided by this agency.

Signature	Date
-----------	------

CONFIDENTIALITY: Whether you decide to register to vote or not, your decision will remain confidential. **IF YOU BELIEVE THAT SOMEONE HAS INTERFERED** with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Office of the Secretary of State, 419 State Capital, Santa Fe, NM, 87503 (phone: 1-800-477-3632). (12/01/09)

Applicant Information

<p>Special Needs Information</p> 	<p>If you are a person with a disability and you require this information in an alternative format, or require a special accommodation to participate in any public hearing, program or services, please contact the NM Human Services Department toll-free at 1-800-432-6217 or through the New Mexico Relay System TDD at 1-800-659-8331 or by dialing 711. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (08/22/08)</p>
<p>Your Civil Rights</p>	<p>All programs administered by the Human Services Department (HSD) are equal opportunity programs. If you believe you have been treated unfairly because of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public assistance program, you may file a complaint. Complaints of discrimination may be filed with the New Mexico Human Services Department central office or the local Human Services county office. Complaints of discrimination about the Supplemental Nutrition Assistance Program may be filed with the USDA, Director, Office of Civil Rights Room 326 W, Whitten Bldg., 1400 Independence Ave, S.W. Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). Complaints of discrimination about Cash Assistance and Medical Assistance programs may be filed with the Office of Civil Rights, Department of Health & Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202 or call (800) 368-1019 (voice) and (214) 767-8940 (TDD). (09/2/09)</p>
<p>Your Privacy</p>	<p>The information you give HSD will be used to determine whether your household is eligible or continues to be eligible to take part in HSD programs. We will check this information through computer matching programs. This information will also be used to make sure that you meet program rules and help us to manage the program.</p> <p>This information may be given to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of picking up persons fleeing to avoid the law.</p> <p>If you get benefits that you were not eligible for and have to pay them back, this is called a claim. If your household gets a claim against it, the information on this application including all social security numbers, may be given to Federal and State agencies, as well as private claims collection agencies for claims collection action.</p> <p>Providing the requested information, including social security numbers of each household member is voluntary. However, each person applying for assistance must give a social security number or it will result in the denial of program benefits to each individual applicant failing to give a social security number. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information or social security numbers. Any social security numbers given will be used and disclosed in the same manner as social security numbers of eligible household members.</p> <p>We also check with other agencies, the federal Income and Eligibility Verification Service (IEVS) and The Public Assistance Reporting Information System (PARIS) about the information that you give us. This information may affect your household eligibility and benefit amount. (10/23/2009)</p>
<p>Fair Hearing Rights</p>	<p>If you do not agree with a decision made on any matter concerning your household's participation in any program through HSD, you and/or your representative, may ask for a fair hearing. A fair hearing may be requested either orally or in writing, within 90 days of the date a notice of a decision on your case was mailed. You will have the right to examine, prior to the hearing, your case file, and any documents used in the determination of the appealed action. Yourself, another household member, or a person you have asked to represent your household, such as a friend or relative, may present your case. You have the right to have legal counsel represent your household at the hearing.</p>
<p>If You Need More Information</p>	<p>Call 1-800-432-6217 or visit the Human Services Department's website at: http://www.state.nm.us/hsd/isd.html Human Services Department is an equal opportunity provider.</p>